

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-019563**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 098

Primary-Registration District No. \_\_\_\_\_

Registrar's No. 54

**FILED JUN 4 1963**

1. PLACE OF DEATH a. COUNTY <b>Daviess</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Daviess</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Jamesport</b>		Length of stay in '1b <b>6 Mo.</b>	c. CITY OR TOWN <b>Jamesport</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>At Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>Edward</b> Last <b>Grice</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-25-89</b>
9. AGE (last birthday) <b>73</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (City and state or country) <b>Linn Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>D. W. Grice</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Singelton</b>	
14. NAME OF HUSBAND OR WIFE <b>Sadie E. Merrick</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>	
16. SOCIAL SECURITY NO. <b>64</b>		17. INFORMANT <b>Mrs. Sadie Grice</b> Address <b>Jamesport, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: <b>Arteriosclerosis</b> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <b>Dec. 62</b> to <b>May 23 63</b> and last saw her alive on <b>May 22 63</b> Death occurred at <b>5:00 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>F.B. Bailey, D.O.</b> (Degree or title)	
22b. ADDRESS <b>Jamesport Mo.</b>		22c. DATE SIGNED <b>5-23-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-26-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. O CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>Linn Co., Mo.</b>
24. FUNERAL DIRECTOR <b>Gipson-Whitaker</b> ADDRESS <b>Trenton, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-25-63</b>	
26. REGISTRAR'S SIGNATURE <b>Walter M. Englehart</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AUG 8 1963

*No Permit Returned*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Geo. D. Whitaker*

Licensed Embalmer No. 4770

P. O. Address *Shenandoah, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.